Depression essay

Psychology

| | Risk factors and protective factors in adolescents with depression | | | Tanya Vassos16514793Word count: 1, 978La Trobe University, Melbourne | | Risk factors and protective factors in adolescents with depression Adolescence has been found to be a period of high risk for the development of depression. A depressive disorder is present when a depressed mood or lack of motivation and pleasure in usual activities in everyday life is continuously present, whilst also being accompanied by symptoms such as loss of appetite, changes in sleep and weight, decreased feelings of self worth and in severe cases, thoughts of death (Hauentstein, 2002). Depression is the most common depressive disorder in adolescence (Hauenstein, 2002). It is one of the leading causes of substance abuse and suicide in Australia, which has caused suicide rates to triple in adolescent males and doubling in adolescent females in the last 30 years (Glover, Burns, Butler & Patton, 1998). Additionally, depression worsens with the age of the adolescent, as Glover et al. (1998) found that it increased from 13% in year 7 students to 22% in year 10 students. Depression can also have a detrimental effect to an adolescents education, health, employment opportunities and development of family and social relationships (Glover et al., 1998). Between 10% to 15% of adolescents with Major Depressive Disorder (MDD) will develop bipolar disorder as mania is continuously present (Hauenstein, 2002). Mania is described as an irritable or extroverted mood, accompanied by a lack of sleep, inflated self-esteem and being extremely talkative (Hauenstein, 2002). Manic episodes usually follow the depressive phase of the disorder. It is essential that early intervention for mental disorders in adolescence is implemented to be able to achieve fast and effective treatment in order to reduce behavioural problems, social and

emotional issues, and to ultimately provide the adolescent with better mental health related outcomes for the long-term (Littlefield, 2008). One of the most studied risk factors associated with adolescent depression is relationships with their parents (Field, Diego & Sanders, 2001). It has been reported that parents of depressed adolescents tend to be less caring, more negative and less supportive (Field et al., 2001). In a study conducted by Sheeber, Hops, Andrews, Alpert & Davis (1998), parent-adolescent interactions were videotaped, and it was shown that parents who had depressed adolescents increased their facilitative behaviour in response to the depressive behaviour demonstrated by the adolescent, therefore suggesting that the parents subconsciously were reinforcing the depressive behaviour (Field et al., 2001). Fields et al., (2001) found that depressed adolescents experienced close to no physical affection with their parents and their verbal relationship with parents was non-existent. Attachment theory provides a valuable example in understanding how important the role of parent-child relationships play in regards to depression (Armsden, McCauley, Greenberg, Burke & Mitchell, 1990). Comfort, security and protection from the parent influence the child's behaviour right through to adolescence and adulthood (Tamplin, Goodyer & Herbert, 1998). A child who experiences insecure attachment is more likely to perceive the world as threatening, thus showing less competence and helplessness, leading to depressive behaviours (Armsden et al., 1990). Parental depression is another risk factor that affects an adolescents depressive behaviour (Fields et al., 2001). In Shiner & Marmostein's (1998) study, 47% of adolescents with depression had depressed mothers, which further lead to an increased risk of medical problems and in some cases, hospitalizing the adolescents suffering

depression (Fields et al., 2001). The characteristics that come along with poor parent relations could ultimately lead to difficulty in school and with their peers. Bullying by peers at school has reportedly been linked to poor mental and physical health in adolescents (Rigby, 1999). During development in adolescent years, when forming of peer relationships are important to most, events in regards to peer relationships such as being bullied, can cause enough damage to the individual which can then lead to depression (Kaltiala-Heino & Frojd, 2011). Although it is unclear whether being bullied applies to students of all ages, studies conducted by O'Moore & Hillery (1991) in an Irish school tested children aged between 7 and 13 who were being bullied by their peers had significantly lower self-esteem. Similarly, a study conducted in an Australian school by Rigby & Slee (1993) found that students aged between 12 and 18 who were exposed to high levels of bullying had low self-esteem and reported to be less happier than others. Loneliness and number of friends has also been found to be related to depression in adolescence, and has also been found to be the most serious problem among adolescents than any other age group (Yaacob, Juhari, Talib and Uba, 2009). Despite loneliness being the most severe in the adolescent life span, the relationship between loneliness and symptoms of depression appear to be identical across all ages and ethnicities. Loneliness is defined as feelings of isolation, disconnection and lack of closeness to friends and family, ultimately linking it to being a risk factor for depression (Yaacob et al., 2009). Yaacob et al., (2009) reported that two separate studies supported this view as there was a significant association between loneliness and symptoms of depression in individuals with MDD. Being exposed to stressful and negative life events such as abuse, divorce,

accidents or deaths has shown to increase the likelihood of developing depression in adolescents (Shortt & Spence, 2006). The link between depression and negative life events is difficult to understand to some degree as individuals create their own life experiences and events through their behaviour. Difficult life events such as parental separation or moving schools or houses, can impact the parents as well as the adolescents (Shortss & Spence, 2006). By impacting on the parents, family conflict and dysfunctional family environments may arise which could ultimately lead to the development of depression in the adolescent (Shorts & Spence, 2006). Protective factors are defined as conditions, skills or events that decrease the likelihood of a disorder or increase its positive outcomes (Shortt & Spence, 2006). They work independently or directly to decrease depression, or in some cases they work by enabling the risk factor to have less of an impact on the individual (Shortt & Spence, 2006). The first step for an individual to combat their depressive symptoms is to be able to identify their protective factors and then develop strategies to fight the disorder. By doing so, this may aid in the prevention of adolescents. Long-term prevention of depression in adolescents will undoubtedly be a difficult task, however if the individual is able to develop several traits that protect them from the risk factors involved and indulge in social experiences that promote health and well-being, they will be on the right track to prevention (Shortt & Spence, 2006). Characteristics of the adolescent or factors that are a part of the adolescent's environment are considered to be protective factors. Individual characteristics that may aid in the prevention of depression include increasing one's self esteem, being able to self-reflect, having high levels of exercise, interpersonal skills and having belief in oneself and a higher power

(Shortt & Spence, 2006). Shortt and Spence (2006) identified the intelligence quotient (IQ) to be a protective factor. It has been shown that having a higher IQ reduces the impact of risk factors such as poverty, perinatal stress and dysfunctional family environments (Shortt & Spence, 2006). A study conducted by Horowitz and Garber (2003) found that adolescents with a higher IQ and whose mothers did not have any symptoms of depression, were found to have a lower likelihood of depression. On the contrary, adolescents with a high IQ and with depressed mothers, were associated significantly with a greater likelihood of depression. In the same study, it was also suggested that adolescents with a higher IQ may have a greater awareness of the suffering being experienced by their mother, leading to feelings of helplessness, causing greater distress to the individual (Shortt and Spence, 2006). Additionally, adolescents with a higher IQ may feel compelled to assist their family with their struggles due to their capabilities, ultimately leading to a heavy load and stress which places them at risk of depression (Shortt & Spence, 2006). Multiple observational studies have shown that being physically active aids in the reduction of depressive symptoms in adolescents (Shortt & Spence, 2006). Exercise has been proposed to improve physiological and psychological health. Although multiple studies have been conducted using samples with clinically depressed patients, they are limited by inadequacies such as poor fitness regimens and poor assessments (Nabkasorn, Miyai, Sootmongkol, Junprasert, Yamamoto, Arita & Miyashita, 2005). However, other previous studies did show a reduction of stress hormones after exercise, measuring urinary cortisol and catecholamine secretions (Nabkasorn et al., 2005). Research has also found that being involved in a team sport in protective in the

development of depression as the individual has a sense of belonging. Increased relationships with parents, familial support and a unified family environment may also assist in the decrease of the likelihood of depression for adolescents who have experienced many life stressors. Supportive and positive relationships with families are linked with adolescents' perceived value and high sense of worth, as well as having a positive outlook on the future (Shortt & Spence, 2006). Being connected more to one's school on a broader level, or to a significant adult other than a parent and the community may also be protective factors. The National Longitudinal Study of Adolescent Health reported that being connected to school and family serves as an essential protective factor across many areas, especially emotional health (Shortt & Spence, 2006). Interventions concerning the community have been used to prevent the use of alcohol and illicit drugs, to improve student learning and achievement and to generally create a healthier community for adolescents to live in. The community can provide adolescents with cultivation, normal behaviours, opportunities to feel worthy and valued and also activities to keep them occupied (Shortt & Spence, 2006). As mentioned previously, adolescence is a period of high risk for the development of depression. Many factors contribute to the increase of the likelihood of depression, including relationships with parents, parental depression, relationship with peers, loneliness and having been exposed to stressful life events. For an adolescent to develop in a healthy manner, it is essential that they are supported by family, peers and communities that provide them with constant positive influences and opportunities. Adolescents require engagement and participation in order to feel accepted and to feel a sense of belonging. Also, living an active and educating life can

aid in the decrease of depression. If these protective factors are implemented to adolescents suffering depression, a change in depressive symptoms will be noticeable, leading the adolescent into adulthood with little or no depressive symptoms as a burden. References Armsden, G. C., McCauley, E., Greenberg, M. T., Burke, P. M. & Mitchell, J. R. (1990) Parent and peer attachment in early adolescent depression. Journal of Abnormal Child Psychology, 18 (6), 683-697. Deykin, E. Y., Levy, J. C. & Wells, V. (1987) Adolescent depression, alcohol and drug abuse. American Journal of Public Health, 77 (2), 178-182. Field, T., Diego, M. & Sanders, C. (2001) Adolescent depression and risk factors. Adolescence, 36 (143), 491-498. Glover, S., Burns, J., Bulter, H. & Patton, G. (1998) Social environments and the emotional wellbeing of young people. Family Matters, 49, 11-16. Hauenstein, E. J. (2002) Depression in adolescents. Journal of Obstetric, Gynecologic, & Neonatal Nursing, 32, 239-248. Kaltiala-Heino, R. & Frojd, S. (2011) Correlation between bullying and clinical depression in adolescent patients. Adolescent Health, Medicine and Therapeutics, 2, 37-44. Littlefield, L. (2008). Towards a comprehensive national early intervention program for children with mental health problems, Australian e-Journal for the Advancement of Mental Health, 7 (1), 1-5. Nabkasorn, C., Miyai, N., Sootmongkol, A., Junprasert, S., Yamamoto, H., Arita, M. & Miyashita, K. (2005) Effects of physical exercise on depression, neuroendocrine stress hormones and physiological fitness in adolescent females with depressive symptoms. European Journal of Public Health, 16 (2), 179-184. Rigby, K. (1999) Peer victimisation at school and the health of secondary school students. British Journal of Educational Psychology, 69, 95—104. Shortt, A. L., & Spence, S. H. (2006) Risk and protective factors for depression in youth. Behaviour

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